

FILED DEC 19 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45957
STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registration District No.

11875

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Length of stay in lb		2279 STREET ADDRESS 2716a Lucas		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie				First Jackson		Last 57	
4. DATE OF DEATH 12 7 57		Month 12 Day 7 Year 57		5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 8-7-18		9. AGE (In years last birthday) abt. 39		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Nashville Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Not Known				14. MOTHER'S MARRIED NAME Not Known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Address Mrs. Mary Wright-2916 Lucas			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) 443 X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443 X						INTERVAL BETWEEN ONSET AND DEATH Undet.	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)					
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION St. Louis, Co., Mo.		20g. COUNTY		20h. STATE	
21. I attended the deceased from 11-25-57 to 12-7-57 and last saw her XXX alive on 12-7-57 Death occurred at 7:12 A m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Paul H. Larson		(Degree or title) M.D.		22b. ADDRESS 2601 Whittier Street		22c. DATE SIGNED 12-10-57	
23a. BURIAL, CREMATION, REMOVAL, etc. (Specify) Removal		23b. DATE 12-12-57		23c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Co., Mo.	
24. FUNERAL DIRECTOR A. L. Beal Und.-4303 Delmar		ADDRESS		25. DATE RECD. BY LOCAL REG. DEC 11 57		26. REGISTRAR'S SIGNATURE J. Paul Smith, M.D.	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed A. D. Richardson

Licensed Embalmer No. 290

P. O. Address 205 S. La

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.